PATIENT REGISTRATION AND MEDICAL HISTORY

Date:__/___/____ Email Address ________________________________@______________

Patient ____
Last Name First Name Middle Initial

Home Phone ( ) ____-________Work Phone ( ) ____-_______Cell Phone ( ) ___-_____

____ ______ _____ ____
Street address City State Zip

Sex: M F Birthday_____/____/______ Status: Married Single Minor

Employer / School_____________________________Occupation: __________________________

Spouse's Name:_____________________Birthday :___/____/____Phone # ( ) ____-________

In ease of Emergency, contact (specify someone who does not live in your household) Name: _______________ tel.#___-_____

DENTAL INSURANCE

Primary insurance

Name of the Subscriber:__________________________________Birthday:____/___/____SSN of the Subscriber :___________________

Group #: _________________Name of the insurance company:____________________relationship to patient _____ _______

Secondary Insurance

Name of the Subscriber:_________________________________Birthday:___/___/____SSN of the Subscriber:________________

Group #: _________________Name of the insurance company:____________________relationship to patient ______________

Assignment and release

I certify that I, and/or my dependents(s) have insurance coverage with ____
Name of ins. comp.

And assign directly to Dr. Surbhi Chandna all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

___________________________________ ____
Signature of patient, Parent, guardian or personal rep. Please print name of patient, parent, guardian or personal rep.

__ ___ ________________
Date Relationship to patient

DENTAL HISTORY

Reason for today's visit___________________________________Former Dentist__________________City/state____________

Date of last dental visit _____/_____/_____ Date of last dental x-rays ____/____/_____

Please circle to indicate if you have any of the following: **BAD BREATH / BLEEDING GUMS / SENSITIVITY TO HOT OR COLD/ DRY MOUTH / LOOSE OR BROKEN FILLINGS / GUMS SWOLLEN OR TENDER/ JAW PAIN/ PERIODONTAL** IS / **TX.GRINDING TEETH / SORES IN YOUR MOUTH / MOUTH PAIN /**
HOW OFTEN DO YOU FLOSS?______________________AND BRUSH? ____________________________

FINANCIAL POLICY

Dr. Surbhi Chandna
3801 N Fairfax Drive, Ste 25
Arlington, VA 22203

Our commitment is to provide quality dental care to the entire family though exceptional service and the utilization of advance technology.

Methods of payment

1. Cash, Check, or Credit card (Visa, MasterCard)
2. Dental insurance (described below)

Payment is required when services are rendered unless prior financial arrangements have been made.

Dental insurance (where applicable)

1. We are please you have dental insurance, and our office will assist you in obtaining the maximum benefits specified in your contract. However, your insurance contract is between you, your employer, and the insurance company.
2. As a courtesy to you, we will file your insurance and accept assignment of benefits. We ask that your estimated co-payment and deductible be paid at the time of service.
3. Not all services are covered benefit in all contracts.

Related information

1. For return checks, a charge of **$25.00** will be applied and balances older than 60 days may be subject to additional interest charges.
2. In the event that the account is not paid and we refer the account to collection, you will be responsible for a **$25.00** fee incurred for the collection of your bill (i.e., attorney fees, court fees, and collection agency fees)
3. We reserve the right to charge **$50.00** for appointments canceled or broken without 48 hours of notice. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment has been made please remember that this time has been reserved exclusively for you.

1 have read and understand the above information. I understand that I am responsible (regardless of my insurance) for any charges incurred from services rendered. I agree to be responsible for any charges not paid by my dental plan. I understand that should my account be placed with an agency or attorney for collections, then I agree to be responsible for all cost incurred in the collection of my account, including attorney's fees, interest at 1.5% per month (18% per annum), and all court costs.

Patient name (Please Print): ____

Signature of patient or responsible party:______________________ Date: _____________

Name: ____ Date:_____/_____/_____

HEALTH HISTORY

Physician's Name____Phone #_____-_______

Please circle to indicate if you had or have any of the following:

	AIDS/HIV		KIDNEY DISEASE
	ANEMIA		LOW BLOOD PRESSURE
	ARTHRITIS		MITRAL VALVE PROLAPSE
	ARTIFICIAL HEART VALVES		NERVOUS PROBLEM
	ARTIFICIAL JOINTS		PACEMAKER
	ASTHMA		PSYCHIATRIC CARE
	BACK PROBLEMS		RADIATION TREATMENT
	BLEEDING ABNORMALLY WITH EXTRACTIONS OR SURGERIES		RESPIRATORY DISEASE
	BLOOD DISEASE		RHEUMATIC FEVER
	CANCER: ____________________		SCARLET FEVER
	CHEMICAL DEPENDENCY		SHORTNESS OF BREATH
	CHEMOTHERAPY		SINUS TROUBLE
	CIRCULATORY PROBLEMS		SPECIAL DIET
	HEART SURGERY		SKIN RASH
	DIABETES		STROKE
	EMPHYSEMA		SWOLLEN FEET
	EPILEPSY		SWOLLEN ANKLES
	FAINTING		SWOLLEN NECK GLANDS
	DIZZINESS		THYROID PROBLEMS
	GLAUCOMA		TONSILLITIS
	HEADACHES		TUBERCULOSIS
	HEART MURMUR		TUMOR ON HEAD
	HEART PROBLEMS		TUMOR ON NECK
	HEPATITIS: ____________________		VENEREAL DISEASE
	HERPES		PREGNANT
	HIGH BLOOD PRESSURE		HIGH CHOLESTEROL
	JAW PAIN		OTHER: ____________________

ALLERGIES

ASPIRIN BARBITUTATES CODEINE IODINE LATEX LOCAL ANESTHETIC PENICILLIN SULFA OTHER

MEDICATION Please list any medications you are currently:

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OFFICE POLICY AND FINANCIAL AGREEMENT If you are unable to keep an appointment, we ask that you kindly provide us with at least 48 Hours notice. This courtesy on your part will make it possible to give your appointment to another patient. Patients will be billed for late cancellations and or no-shows. Please schedule only definitive appointments. Same day or next day appointments will be given, based upon availability. We are closed on Fridays, weekends and major holidays. As every effort is made to be on time for our patients, we ask that you extend the same courtesy to us by arriving a few minutes before your scheduled appointment. Co-payments and co-insurances are due at the time services are rendered. Forms of payment accepted by the office are check, Debit Card, Visa and MasterCard Credit Cards.

I,_____________________________________FULLY UNDERSTAND DR CHANDNA'S OFFICE POLICIES AND FINANCIAL AGREEMENT. Signature of yourself or parent, Guardian or personal representative ____________________Date: ___/____/____

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate Information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals co other dentists of specialists, and return tor scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome,

Please read and initial the items below and sign at the bottom of the form.

1. Treatment To Be Provided
I understand that during my course of treatment that the following care may be provided;

Examinations_______ Preventative services_________ Restorations_______ Bridges_________

Other______ Patient's Initials______

2. Drugs And Medications

I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues: pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Patient's Initials____________

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examinations, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes as necessary. Patient's Initials

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable. Patient's Initials

_______________________________________ _________________

Patient Signature Date

Dr. Surbhi Chandna
3801 N Fairfax Drive, Ste 25
Arlington, VA 22203

(703) 525-7471

ACKNOWI.EDGMENT OF RECEIPT OF NOTICE OF *PRIVACY PRACTICES*

"You May Refuse to Sign This Acknowledgment*

I,____have received a copy of this Office's Privacy Notice.

Please Print Name

____________________________ ________________

Signature Date

I give permission for my information to be shared with the following person(s):

____

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For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

___Individual refused to sign

___Communications barriers prohibited obtaining the acknowledgment

___An emergency situation prevented us from obtaining

___Other (Please Specify)

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